Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Community Living Area A
Name of provider:	Muiríosa Foundation
Address of centre:	Laois
Type of inspection:	Announced
Date of inspection:	12 December 2018
Centre ID:	OSV-0004084
Fieldwork ID:	MON-0021868

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The designated centre comprises three community houses in close proximity to the nearest small town, which provide a full time, long term service to nine residents, both male and female with an intellectual disability. The provider describes the service as providing a range of services to support adults with an intellectual disability, as reflected in their person centred support plan, with the core purpose of supports to be to enable the person to be a participant in their community and to contribute to that community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
12 December 2018	10:30hrs to 18:30hrs	Julie Pryce	Lead

Views of people who use the service

On the day of inspection there were eight residents living in the centre and the inspector met and engaged with five residents.

Residents had various different methods of communicating, some residents engaged verbally, some residents engaged through physical gestures or facial expressions and some residents did not engage easily with persons they were not familiar with and this was respected.

Where residents spoke to the inspector they said that they were happy in their homes, and where arrangements were changing, they said that they were pleased with the changes.

Other residents were seen to be at home and content in the centre. It was apparent from interactions with staff that residents were comfortable and familiar with staff members. Records of discussions around choice for residents clearly indicated that their preferences were sought.

Family members informed the inspector that recent changes in relation to the compatibility of residents in one of the houses had made a positive impact, and that staff ensured that the house was a happy home for residents.

Capacity and capability

Overall the inspector found the centre to be effectively managed, with a clearly defined management structure in place with clear lines of accountability, and an appropriate person in charge and area manager, but that governance processes were not adequate to ensure consistency of oversight.

The person in charge was appropriately skilled, experienced and qualified, and provided details of professional development. She demonstrated a detailed knowledge of the needs of residents, and was involved in the supervision of staff.

A suite of audits was in place and had been regularly undertaken, including audits of medication managements and finances. The six monthly unannounced visits on behalf of the provider had been undertaken, one in May and one in October of 2018.

However, the report of the October visit had not been made available to the person in charge at the time of the inspection. The visit in May had been conducted when the house was empty, and the comments were therefore vague and not meaningful, for example some of the questions on the audit form were answered by 'not available', or 'no staff present'. The actions required were also vague in some cases. Of those required actions reviewed by the inspector not all had been undertaken. For example it had been identified that accessible versions of personal plans were required, but this had not been done. It was therefore unclear that the provider sufficient oversight to ensure the best outcomes for residents.

However, an annual review had been undertaken, and while the required actions were still within their timeframe, there was evidence that progress was being made towards them.

Meetings were held both at a local managers level, and at house team level. However house team meetings had not been conducted regularly, and the notes of these meetings appeared to be an update from a staff to the person in charge, rather than a discussion or review of practices, or plans for improvements, other than vague comments about updates being required. There was no follow up or monitoring of these suggestions and therefore no evidence that required actions were competed, or brought forward if not completed.

There were appropriate staffing arrangements in place for the most part, in that the numbers of staff and the skills mix ensured that the needs of residents were met in two of the three houses. The third house had sufficient staff to meet the daily care needs of residents, but there was only one staff member on duty every evening so that there was limited opportunity for activities, unless all the residents were involved, and this had an impact on residents as evidenced in residents' meetings, comments from family members, and from comments made by residents.

Staff had received mandatory training, and were able to demonstrate knowledge of the content of their training, and of the support needs of residents. There was regular structured supervision of staff. Staff files were not examined by the inspector during this inspection, but the human resources department of the organisation presented a clear system of monitoring of staff files to ensure that all the requirements of the regulations were met.

There was an appropriate complaints procedure in place, and residents and families were aware of who they should approach if they had a complaint. Staff were aware of the actions they needed to take should they receive a complaint. A complaints log was maintained which included a record of any actions taken following a complaint, and the satisfaction of the complainant.

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents for the most part, but there were insufficient staff to ensure activities of choice for some residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training and additional training specific to the needs of residents, and were appropriately supervised.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place which identified the lines of accountability and authority. There were some monitoring systems in place, but the six monthly unannounced visits and the system of staff meetings did not demonstrate that the provider had adequate monitoring and oversight arrangements in place.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The processes in relation to new admissions were effective and person centred.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service.

Judgment: Compliant

Regulation 31: Notification of incidents

All the necessary notifications had been made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place which was available in an accessible version. A complaints log was maintained, Residents and family members were aware of the procedure if they wished to make a complaint.

Judgment: Compliant

Quality and safety

Overall the provider had put arrangements in place to ensure that residents had support in leading a meaningful life and having access to healthcare, and were supported to make choices. However, improvements were required in some of the systems in relation to the management of risk.

There had been an incident where a resident had a fall, and in accordance with the centre's policy in relation to reporting incidents and seeking any required assistance, staff had phoned the on-call manager. There was no response to this phone call until three hours later. This delay had not been raised at any meetings, and there was no evidence of any action having been taken to prevent recurrence. Whilst this did not have a negative impact on that particular occasion, the inspector was concerned that the process was not robust in the event of a serious incident.

The person in charge submitted information the day following the inspection as to how the issue was being addressed by the management of the centre to ensure a safe response to such calls in the future.

There was, however a detailed risk register in which risks had been identified and risk rated, and which corresponded with detailed risk assessments and management plans which had been regularly reviewed. There was a detailed fire safety risk assessment in place, which included interim measures to ensure the safety of residents pending the provision of a ramp to one of the entrances.

A fire safety audit was undertaken monthly, and regular fire drills had taken place which involved any new resident in a timely manner following admission. There was a personal evacuation plan in place for each resident. There was a system in place for daily checks including a check on access to fire exits, but this was done sporadically, and was not completed for approximately half the days in the two months prior to the inspection, so that it was not clear that clear fire exits were maintained.

There were systems and processes in place in relation to the protection of

vulnerable adults. Staff had received training, and those staff engaged by the inspector were knowledgeable in this area. There were robust systems in place regarding the management of personal monies of residents. There were detailed intimate care plans in place which took into account the preferences of residents regarding who should support them in this area.

Each resident had a personal plan in place which included various sections including personal care, healthcare and communication, and which was indexed so that information could be readily retrieved. Each of the sections was based on an assessment of needs. There was a person centred planning section in each plan, however the goals in this section were vague, and related to information about the current needs and routines of the residents. There was therefore insufficient evidence that all efforts were being made towards maximising the potential of residents.

While residents attended day services in accordance with their needs, and were engaged in various activities including employment, there was limited opportunity for some of them in relation to leisure activities in the evenings and at weekends. A residents' forum was in place, and residents had brought up this issue at the forum, saying that they would like more individual activities in their free time, and mentioned that they would like staff to be available for this. Family members, whilst being very satisfied overall with the service offered to their relatives, and in particular with the staff members, also mentioned additional staff as being an area which could improve the quality of life of residents.

Communication with residents was clearly a priority in the centre. Each resident had a detailed communication plan in place, and where required an additional assessment had been completed in relation to how residents communicated discomfort or pain. Staff were knowledgeable in relation to the information in these plans, and it was clear from interactions observed by the inspector that individual methods of communication were consistently used.

Consultation with residents took various forms. There were residents' meetings and a wider residents' forum for those residents who chose to be involved. For others consultation took place on an individual basis in accordance with the preferred methods of communication of residents.

Where residents required positive behaviour support there were detailed assessments, risk assessments and management plans and behaviour support plans. Behaviour support plans were detailed, and staff were familiar with the guidance documented in them. The inspector observed the implementation of some of the plans, and there were aids in place throughout the centre for others. Implementation was recorded, and detailed records were kept of any incidents of behaviours of concern. Monthly meetings were held where the data was analysed and plans were reviewed.

There were safe practices in relation to the ordering and storage of medications. Staff had been trained in the safe administration of medications, and this training included an assessment of competency. A self medication assessment had been

conducted for each resident. There were audits of medication management, and six monthly pharmacy reviews took place in the centre.

There was robust management of p.r.n. (as required) medications. There was a protocol in place for each of these medications which included guidance as to the circumstances under which they should be administered, and a detailed record of each administration was maintained including the reason for the administration, and the outcome. These administrations were audited on a two monthly basis.

Where staff had any concerns in relation to medications prescribed for residents, referrals were made and reviews were undertaken with the consultant or general practitioner.

Healthcare was well managed and there were healthcare plans in place. These plans were developed in accordance with the recommendations of members of the multi-disciplinary team. Any short term or new conditions were well managed, appropriate referrals were made and care plans were in place, for example for the management of a wound or short term illness.

Whilst the service offered to residents was of a long term nature, where a new resident was admitted the procedure was well managed. There was a transition plan to ensure the compatibility of residents, and to gradually introduce residents to each other.

The premises, which comprised three community houses, were well maintained, and changes were made in accordance with the needs of residents. For example a plan had been developed in conjunction with the occupational therapist for a ramp to be installed in one of the houses to suit the needs of a new resident. However, in one of the houses where a resident preferred to take meals alone, a large dining table had been put in the living room which took up most of the space, and made the room inaccessible to other residents.

Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences.

Judgment: Compliant

Regulation 13: General welfare and development

Residents required further support to ensure that their needs in relation to social activities were met.

Judgment: Substantially compliant

Regulation 17: Premises

The design and layout to the premises was appropriate to meet the needs of the residents for the most part, but the location of a dining table to meet the needs of one of the residents made the living room inaccessible to others.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were processes in place to assess and mitigate identified risks, however the on-call system for emergencies was not effective.

Judgment: Not compliant

Regulation 27: Protection against infection

Effective measures were in place to ensure protection against infection.

Judgment: Compliant

Regulation 28: Fire precautions

Precautions had been taken against the risk of fire for the most part, but daily safety checks were not consistent.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Structures and procedures were in place to ensure the safe management of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place based on an assessment of needs. Plans had been reviewed regularly and were information was easily accessible. However, appropriate goals in relation to the maximising of residents' potential were not in place.

Judgment: Substantially compliant

Regulation 6: Health care

Provision was made for appropriate healthcare.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were robust systems were in place to respond to behaviours of concern.

Judgment: Compliant

Regulation 8: Protection

Appropriate systems were in place in relation to safeguarding of residents.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were upheld, and the privacy and dignity of residents was respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Community Living Area A OSV-0004084

Inspection ID: MON-0021868

Date of inspection: 12/12/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider has ensured that there is 4 extra hours per week has been assigned to one particular residence to ensure choice around social activities. A system has also been put in place that whenever a resident has a planned social activity that extra staff will be allocated for that resident.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Regulation 23 (1)(c) Staff Meetings: A new system in relation to staff meetings has been put in place. Issues in relation to Residents arising from monthly reports will be discussed, actioned and reviewed in a timely manner. Staff meetings will occur monthly. Regulation 23 (2)(a) A new 6montly audit tool for unannounced inspections has been developed which will identify any issues and ensure that they are actioned and reviewed in a timely manner.	

Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: An extra four hours per week has been provided to ensure choice in relation to residents' social activities. A system is also in place to ensure that if any resident chooses an activity that extra staff will be allocated to support this.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A smaller dining room table has been sourced to ensure access for all residents to the living room.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: On call out of office emergency service was reviewed and guidelines submitted to Hiqa Inspector. The on call emergency protocol was discussed at all team meetings. This service will also be periodically reviewed by the Area Director and Regional Manager.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The importance of daily monitoring of fire exits was raised at team meetings and manger to review these on a weekly basis.	

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Each individual's person centred support plan will be reviewed with clearly identified goals to maximize the potential of each individual. All individual's will be involved in these reviews and will set out their goals with support from staff and families.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	01/02/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/02/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and	Substantially Compliant	Yellow	25/01/2019

	objectives of the service and the number and needs of residents.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	25/01/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	08/02/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	14/12/2018

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	25/01/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	29/03/2019